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Enhancing the Wellbeing of Incarcerated Females: A Pilot Study

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Abstract
Piloting the Group Positive Psychotherapy program (Seligman, Rashid & Parks, 2006) with dually diagnosed mothers age 13 to 22, who are under penal supervision; this project will attempt to counter traditional interventions by increasing positive emotion, meaning and engagement. Phase 1: The program will be administered over 7 a week period to 20 professional staff members. Measures on approaches to happiness and quality of life will be taken pre and post intervention. Phase 2: The program will be administered over a 6 week period to a group of 24 residential clients. Measures on depression and quality of life will be taken pre and post intervention.

Keywords
Positive Psychotherapy, at risk youth, incarceration, females, prison, women, drug addiction, wellbeing

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Positive Psychology is for all of us, troubled or untroubled, privileged or in privation, suffering or carefree. The pleasures of a good conversation, the strength of gratitude, the benefits of kindness or wisdom or spirituality or humility, the search for meaning and the antidote to "fidgeting until we die" are the birthrights of us all.

Martin E.P. Seligman

Introduction

For some people, the concept of wellbeing never enters into their purview or can seem out of reach and many believe that they don't have the tools or money to achieve it. This is particularly true for people who come from troubled family or social environments or who have committed infractions that have led them into the federal or state penal systems. This is a sad state of affairs because wellbeing is possible for most people who understand that it takes intentionality and positive habit development. Wellbeing is an integrative process that includes the development of behaviors that reinforce positive processes in the cognitive, physical, psychological, and spiritual realms. In small doses everyday, people can feel better and enjoy the processes that lead to wellbeing. Walks in the woods, appreciating a task well done, enjoying peaceful meditation, or a good laugh are all ways to walk the life toward wellbeing. Efforts to achieve wellbeing can also be achieved through participation in purposely planned positive activities or interventions. It is paramount for Positive Psychology practitioners to create positive interventions that will lead people to experience more positive emotion (Fredrickson, 2002) and happiness.

The concept of wellbeing is not just about increasing positive emotion and happiness and should not be taken lightly; it has important psychological and practical elements. Psychological wellbeing includes self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryff & Singer, 2002). And in the realm of daily living, wellbeing is viewed in terms of stable employment, housing, and support of dependants, and volunteer service in the community (Lucenti & Gorczyk, 2005).

The challenge that this Capstone project will attempt to address is how best to deliver effective and salient positive interventions to populations that have traditionally not focused on wellbeing. Those who have made decisions or had experiences that have led them to either be at risk for problems or are already deeply entrenched in difficult lives that may include poverty level living conditions, drug addiction, poor mental health, criminality, or adolescent parenting. In particular, this paper will look at applying the tenets of Positive Psychology: strengths, optimism, hope and resiliency to women that are in trouble; who have been incarcerated and are parenting; who suffer from mental illness and substance abuse. Why is this population so important? By addressing the wellbeing of the mothers, it is the intention of the author to increase the wellbeing of the children. They are our future.

Applying the practices of Positive Psychology to this group of women is important for the subjects under discussion and as noted their families, however it is also important for the field itself. Even though the founder of Positive Psychology, Dr. Martin Seligman believes that "Positive Psychology is for all of us, troubled or untroubled, privileged or in privation, suffering or carefree", there is a perception that focusing on the positive is a luxury that only the privileged enjoy. This misperception might arise from Maslow's hierarchy of needs in that self actualization can only occur after all of the basic needs are met in his pyramid model (Maslow, 1982) and might also be supported by the more well known positive speakers such as Anthony Robbins, who charge high fees for attendance to his forums or for his products. Additionally human's negativity bias can lead people to believe that the positive approach is less important than their troubled "reality".

Reflecting on two years of work teaching career efficacy skills in the state of Vermont penal system, this author has seen a personal view of numerous female inmates and their challenges to enjoying happiness and wellbeing. Martin Seligman (2002) postulates that there are three ways to be happy: through meaning, engagement and pleasure. The incarcerated women with whom this author has worked rarely seem to enjoy meaningful or engaged lives and their pleasure seems to be acquired through short lived chemical or personal dependence. While resilient from the standpoint that they are still alive, these women are frequently depressed, often engage in rumination and catastrophize future events (Reivich & Shatté, 2003). There are few activities available in prison to help the women overcome these habits. Beyond the occasional exercise class or volunteer activity, much of the day is spent either watching TV or trying to stay out of skirmishes with other inmates. Very little time is spent in productivity. The women in Vermont prisons are also frequently given prescription drugs. By the state's own estimates, Vermont has the highest percentage of inmates on psychotropic medication of any state in the country and the highest number of inmates getting more than one psychiatric medication (Gram, 2007).

The goal of the program would be to support these women in finding their strong, resilient selves. It is the perception of this author that the social services system has not supported the independence or strength based applications that people need. Instead what has been created is a system that creates dependence rather than independence. The road to wellbeing is a challenging one on which people need to be strong and intentional in their efforts.

The final section of this project will include an application program for women in the Burlington Vermont region. The Lund Family Center which works with over 4,000 young

women and adolescents a year, the majority of whom are under corrections care, has asked this author to create a program that could be used to increase the wellbeing of their clients. These young women often enter the Lund Family Center in deeply troubled circumstances and leave treatment to return to poverty level conditions. The staff and leadership of the Lund Family Center are looking to Positive Psychology support their clients in finding their strengths and making better life decisions. Additionally, the staff of the center has also requested a program for their use. While the focus will be on the client population, the opportunity to create a program for the staff is welcome and will be addressed. It is the intention that the program created for the Lund Family Center will have the depth that is needed for positive application for the clients at hand and the breadth to be applied in to women in the state prison system. In fact this program will be a pilot program for later use in the larger state system.

Positive Psychology: A New Approach

Positive Psychology is a discipline that was named by Martin Seligman in 1998. It is the study of wellbeing and the good life, what is right with people and the world and assumes that people have character strengths and are indeed prone toward growth and flourishing (Peterson, 2006). “Business as usual” psychology comes from a disease model that assumes that people are defective and need fixing. “People are seen as flawed and fragile, casualties of cruel environments or bad genetics, and if not in denial then at best in recovery” (Peterson, 2006). Positive psychologists believe that the deficit based model is incomplete and seek to build on what is right, rather than on what needs fixing.

Positive Psychology is not just about happiness, although we know that happy people live longer and are more successful at work, in school and in relationships (Lyumborsky, King &

Diener, 2005). Pertinent to the subject at hand is also the concept of "post traumatic growth". Tedeschi and Calhoun (1995) were among the first to research and document post traumatic growth whereby people actually grow after trauma, not become depleted. The pathways to post traumatic growth are (1) Acceptance, where one decides to confront the situation realistically and not engage in self pity, (2) Affirmation that there is meaning and goodness and purpose in life, (3) Determination for recovery, (4) Confidence in the self to recover, (5) Faith: often after trauma people find a spiritual or religious affiliation, (6) Relationships with others become stronger and support is recognized (7) Optimism and hope for the future (Wong, 2003). Wellbeing is not an easy task for many and it takes an intentionality and decisive choice to engage in changing one's life habits.

The Importance of Habits and Intentionality

To seek wellbeing it takes a consciousness of thought, an intentional mindfulness toward feeling better and making better decisions. Mindfulness is an awareness of and attention to what is taking place in the present. Intentional mindfulness can be defined as purposeful consciousness to direct one to positive outcomes. Inherent in this perspective is the belief that human beings are active, and disposed toward development (Self Determination Theory: An approach to human motivation and personality, 2006).

Intentional mindfulness takes effort and must be developed through habitual practice and attention; this is not a new idea. From Aristotle to present, psychologists and philosophers claim that to truly live the good life, people must work to gain control of thoughts, exercise focus and develop habit forming behaviors that accelerate toward the action(s) that they desire. Aristotle saw happiness as the highest goal achieved through rational thought, and habits as virtues. Aristotle said "what is the good in all matters of action? As to the name, there is almost complete

agreement… happiness". To achieve true happiness or "Eudemonia", a life lived through rationality; one must pursue excellence through thought and reason. Happiness is not possible without excellence or virtue and virtues are learned through habits. Aristotle also claimed that there are individual differences in human beings and that all of the virtues can be analyzed by seeking the mean; which is dependant on the individual and the situation (Melchert, N., 2002).

William James (1892) wrote at length about habits, their merit toward right motives, and their relationship to the nervous system, "we must make automatic and habitual as early as possible, as many useful actions as we can". He noted that "habitual concentrated attention, energetic volition, and self-denial in unnecessary things…will [make a man] stand like a tower when everything rocks around him" James also asserted that "Though the spontaneous drift of thought is all the other way, the attention must be kept strained on that one object until at last it grows so as to maintain itself before the mind with ease". James postulated about happiness and its relationship to healthy-mindedness and he noted that the single minded approach of only seeing good in the world might be challenging but that "when we are feeling happy, we cannot feel sad" Why doesn't everyone enjoy healthy mindedness? James believed that not everyone had the ability for healthy-mindedness (Pawelski, 2003). In regard to this question, philosopher James Pawelski (2003) asserts that there is a further level of definition in that "there are actual healthy-minded people who have made the decision to see the world as potentially good and potentially-healthy minded people who have not made that decision but who have the ability to".

Mihaly Csikszentmihalyi (1990) states that "those who take the trouble to gain mastery over their consciousness …live a happier life". He defines consciousness as "intentionally ordered information" and postulates that attention is the way that people retrieve these bits of information. Importantly, he says that "the mark of the person who is in control of consciousness

is the ability to focus attention at will". He also noted the importance of habit and practice in obtaining flow, which are periods of deep concentration "when the information that keeps coming into awareness is congruent with goals [and] psychic energy flows effortlessly". Csikszentmihalyi says that the more often people can put themselves in a state of flow, the happier they will be and that it in fact takes practice and skill to obtain flow on a regular basis. Based upon the aforementioned theorists, it can be concluded that controlling thoughts and developing positive habits will instill deep and meaningful happiness. But why is it so difficult for people to focus their attention at will, are we only rational beings?

Jonathan Haidt (2006) argues against the concept that humans are "rational agents" and believes that "human thinking depends on metaphor. We understand new or complex things in relation to things we already know". He offers the rider and the elephant analogy to explain human's weakness of will. "We assume that there is one person in each body, but in some ways we are each more like a committee whose members have been thrown together to do a job, but often finds themselves at cross purposes." He postulates that life is not just about rational thought but about rational thought after very gut level reactions. If one agrees with Dr. Haidt, then we live our lives in relation to what we know, to what we have experienced. How then if a person has lived a life with pain, suffering and abuse, and behaved in ways that society sees as immoral does that person achieve wellbeing? To really succeed in living the good life, and taming that elephant, this author believes that it takes true intentional thought and a spiritual and consciously aware approach to living. It also requires an appreciation of one's approaches to happiness (Peterson, Park & Seligman, 2005b) and character strengths (Peterson & Seligman, 2004) to get them there.

An Integrated Approach: Self-Regulation, Self-Determination and Self-Efficacy

In looking at the aforementioned scholars, theorists and philosophers, it can indeed be said that to achieve wellbeing, one must take an intentional integrative process approach; encompassing behaviors that reinforce positive focus in the physical, psychological and spiritual realms. Mutrie and Faulkner (2004) argue that physical activity and exercise are behaviors that will help humans and communities prosper. They suggest that "at an individual level, regular exercise has the capacity to prevent mental illness, to foster positive emotions, and to buffer individuals against the stresses of life".

Shapiro, Schwartz & Santerre (2002) connect meditation with Positive Psychology, arguing that the focus of research on meditation has been on the traditional medical model framework of "symptom alleviation" and not on "healing and development". They define meditation as a "family of techniques which have in common a conscious attempt to focus attention in a non-analytical way and an attempt not to dwell on discursive, ruminating thought". Key components are the words "conscious", "intention", and "attempt" which they argue focus on the process of meditation vs. the goals. The authors reveal numerous empirical findings showing the positive effects of meditation on wellbeing. Areas of research show that meditation affects both mind and body in allowing "profound states of psychological rest" (Shapiro, Schwartz & Santerre, 2002), improved alertness, increases in endorphins, and reduced stress related hormones. Stated research also shows increases in memory and intelligence, creativity, self-esteem, positive affect, and spirituality measures.

Self-regulation is the process whereby people maintain stability and adapt to change. It is based on "feedback loops which can be enhanced through attention. However, the intention with which attention is directed may be crucial." (Shapiro & Schwartz, 2000). Intentional mindfulness

is central to self regulation and wellbeing, effecting motivation, self efficacy and Emotional Intelligence. Psychologist Roy Baumeister's research shows that like a muscle, self regulation can be strengthened and regular exercise of self regulation increases self regulation in other areas. "It is possible to make the self stronger and thereby increase its ability to rise above situational demands to guide behavior" (Baumeister, Gailliot, DeWall, & Oaten, in press). Self regulation can also be depleted. "Ego depletions appear to reduce inhibitions…releasing socially undesirable behaviors that may ordinarily be subject to controls" (Baumeister, in press). Depletion can lead to unhealthy behaviors such as overeating, increased alcohol consumption, sexual infidelity, and withdrawn social interactions. By being aware of the propensity for depletion, one could postulate that intentional mindfulness could allow one to channel these tendencies for undesirable behaviors into more healthy directions.

Brown and Ryan (2004) argue that autonomously motivated behavior is self determined and one of the ways to foster intrinsic motivation from extrinsic motivational forces is through mindfulness. "Research suggests that consciousness when brought to bear on present realties, can introduce an element of self direction that in what would otherwise be nonconsciously regulated, controlled behavior" (Brown and Ryan, 2004). Mindfulness is also associated with higher wellbeing in terms of its effect on regulating self regulation.

Self efficacy theory as contended by Maddux (2002) is based upon early constructs of personal control. He states that self efficacy is where one believes that they can change a challenging situation based upon their ability to coordinate and orchestrate skills. Self efficacy and self regulation depend on 3 interacting components; "goals or standards of performance, self evaluative reactions to performance and self efficacy beliefs". Self evaluative reactions create emotional reactions that can "enhance or disrupt self regulation" One can argue that intentional

mindfulness and its positive role in self regulation would be a necessary component of strong self-efficacious beliefs.

Salovey, Caruso, & Mayer (2004) define Emotional Intelligence as "involving both the capacity to reason about emotions and to use emotions to assist reasoning". They further state that emotional intelligence includes the abilities to "use emotions to facilitate cognitive activities and motivate adaptive behavior". An emotionally intelligent person can change their moods from negative to positive and the attention of intentional mindfulness is required to not only identify the moods but to make the judgment about whether the mood should be altered or left as is. Programs that report success in developing Emotional Intelligence (Boyatzis and Van Oosten, 2002) reveal that mindfully identifying behaviors to be changed combined with opportunities to practice new skills produce more lasting behavioral changes.

Mindfulness is an awareness of and attention to what is taking place in the present (Compton, 2005) and purposeful mindfulness can be utilized for wellbeing on a regular basis without training. It is clear that intentional mindfulness takes effort and focus. Each theorist illuminated in some part the positive relationship of purposeful attentiveness and self regulation in increasing wellbeing and creating behavior changes that strengthen broader self regulation effects, counteract the effects of ego depletion, and enhance self efficacy and emotional intelligence. In reviewing the research, one would be well advised to make the effort to begin the practice of intentional mindfulness to increase wellbeing. The question that this treatise must address is how do Positive Psychology professionals lead people to this realization and practice? The concept of positive interventions must enter the discussion at this point.

Positive Interventions

It is paramount for Positive Psychology practitioners to create positive interventions that will lead people to experience more positive emotion (Fredrickson, 2002) and happiness through focused thought, habit and effort. Salient positive interventions are those that lead people over time to create habits that instill deep and meaningful happiness (James, 1892). But how do we reach the people who we want to affect and how can we make the positive intervention last?

The concept of positive interventions stems from the theory of meliorism which assumes that improvement of society depends on human effort. Definition parameters for positive interventions should include James Pawelski's (2006) defining characteristics of P1 and P2 positive interventions. P1 refers to the capacity of the intervention to affect greater wellbeing away from zero and P2 refers to the capacity of the intervention to affect greater wellbeing by cultivating pleasant affect, strengths and meaning. P1 therefore, refers to whether or not the intervention is positive in its point of applicability; in terms of clinical versus non clinical population for example. P2 indicates whether or not the method is a positive one. P2 is really a question of "green cape" versus "red cape" thinking (Pawelski, 2006). Positive interventions should be considered tools and are those interventions that are both positive in point of application and positive in method.

A conceptual framework model also developed by James Pawelski outlines the elements of positive interventions and assumes an approach towards the interventions where delivery, active ingredients, target mechanisms and target functions are all considered. There is a noted difference between positive intervention and positive experience. Positive interventions are intentional whereas positive experience is unintentional. Positive intervention doesn't have to work; it just has to be intended to work.

The package or format in which the positive intervention is delivered should be simple, easily measurable, self perpetuating, not cause harm and create genuine lasting change. The active ingredients which cause change are the experiences and physical and emotional states. The target mechanism is the domain in which change occurs; for example changes in affect, attention, physiology, cognition, personal relations or organizations. The target function is the change that is desired within the domain; for instance increased positive self-efficacy, self-determination, motivation, self-regulation, or a more optimistic explanatory style. The desired outcome is the desired change within the target mechanism such as greater happiness or subjective wellbeing, success in reaching goals, improved relationships, or more successful organizations. To analyze the effect of the positive interventions all of the elements should be assessed in terms of the effects.

A successful positive intervention is one that is appropriate to the targeted group or person, easily understood, and creates cognitive shifts that create positive emotion, intentional mindfulness, positively affects habit and motivation and is aimed at increasing wellbeing. This positive intervention model also assumes active participation by the targeted participant(s). Some fine examples of positive interventions can be found in the research of Fordyce (1977), Fredrickson (2006) and Frisch (2006). Fordyce created a happiness intervention that consisted of 14 “fundamentals” that included being more active, increasing close relationships and valuing happiness. He found that his “research-based course on happiness made a difference in happiness and that gains in happiness are not merely an artifact of suggestion effects or a sensitization to the topic of "happiness" itself “ (Fordyce, 1997). Frederickson (2006) created a workplace positive intervention where a 6 week meditation program with a waitlist control group was applied. The resources measured were mental (mindfulness and savoring), psychological (agency

and personal growth), social (relationships) and physical (sleep quality and illness symptoms). They found that in all areas that the length of time spent meditating correlated with increased positive measures in the life satisfaction surveys and in all of the self report measures for the resources.

Positive Intervention in the Prison System

The Vermont Department of Corrections (DOC) is implementing a successful positive intervention for female inmates. This program, organized around the "Habits of Mind" (HOM) curriculum (Costa & Kallick, 2000), seeks to teach inmates life skills through immersion in their everyday environments; work, living unit, school. "This strength-based approach is built on the understanding and integration/utilization of 16 aspects of behavioral intelligence, or life skills that increase ones ability to problem solve effectively (Costa & Kallick, 2000). See Table 1 for a listing of the 16 habits of mind. The inmates are also trained in "Challenging Choices", a program designed to support the participants in intentional thought and present mindedness regarding the choices they could make at critical moments (Lucenti & Gorczyk, 2005). Early results from this program have been promising. Findings show that recidivism has declined for participants by almost 40% and life satisfaction has risen. Additionally, the workforce output and quality in the prison road sign and license plate production areas has increased by 50% (Gorczyk, 2006).

The application of Positive Psychology is evident in this program. Participants develop positive habits, shift their focus to the positive, and learn to control their thoughts. Women have stated to the author that they feel like they "know what to do now", "can act better as a team",

"feel happier" and "can focus on what's important". The DOC program is a positive intervention of the highest order (Compton, 2005).

We know that "positive affect is an active ingredient in human flourishing" (Frederickson, 2006) and one of the main goals that this project will seek to accomplish is to raise the level of positive affect in the females who are targeted. Positive Psychology approaches have also been effective in decreasing or preventing depression. There are many examples that would be outside of the scope of this paper to present. However the work of Reivich & Shatté (2003) and Seligman, Rashid and Parks (2006) are salient to this discussion and will be used in terms of the intervention application.

The Magnitude of the Problem: Women and Families in Crisis

The problem of women and families existing in extreme lack of wellbeing is growing. The United States has increasingly been turning to incarceration for punishment of criminal actions by women and the rate of female incarceration has risen dramatically. Most of these women are single parents of children younger than 18 years of age. Often these women also suffer from histories of physical abuse, substance abuse and depression and their offenses are primarily non-violent and drug related (Greene & Pranis, 2004). Understanding that criminal deviance is often generational in nature, increased incarceration of mothers is resulting in a generation of children who are at risk for repeating the ills of their parents.

Compounding this issue is the birth rate to teen mothers. Although the rate of teen pregnancies has decreased overall in the US (Guttmacher Institute, 2006), more teen mothers are choosing to keep their babies. Often the adolescent parent is also raising the child in

surroundings where there is substance abuse, neglect or criminal behavior. Children raised in these situations frequently become emotionally and financially impoverished themselves as they reach adulthood; overall, the decision to keep a baby in poverty situations is an expensive option from the social service and tax perspectives (Guttmacher Institute, 2006). The statistics do not bode well for our nation's children and the future wellbeing of the United States unless the trend of generational incarceration and poverty is broken.

Mothers in Prison

Women's "rates of incarceration are increasing faster than those of men and they are reentering communities with unique needs related to children and family issues, employment and substance abuse" (O'Brien & Adams, 2002). According to a US Department of Justice report, as of December 31, 2004, 104,848 women were held in state and federal prisons - up from 68,468 in 1995 (U.S. Department of Justice Bureau of Justice Statistics [U.S. DOJ], 2005). According to the World Female Imprisonment List (Walmsley, 2006) "more than one half a million women and girls are held in penal institutions worldwide …and about one third of these are in the United States of America". In fact in 2006 the US had the highest female prison population rate in the world, at 183,400. This shows that in 2 years the US rate of female imprisonment increased by almost 80,000 women. 90% of these women are single mothers with sole care giving responsibilities for their children. Mothers were twice as likely as fathers to have committed their crimes to obtain drugs and three times as likely to have experienced a period of homelessness prior to incarceration (U.S. Department of Justice Bureau of Justice Statistics [U.S. DOJ], 2000).

The last large scale assessment of parents in federal and state penal institutions was held in 2000 by the U.S. DOJ. Data yielded that over half of the 1,366,721 inmates held in state or

federal prison were parents. These parents had an estimated 1,498,800 children under the age of 18 years. This count represents an increase in the number of children affected by parental incarceration by over 500,000 since 1990. The majority of these children live in situations where it is highly likely that their parent's incarceration has a direct impact on family functioning: almost 50% of incarcerated parents lived with their children prior to their prison admission, and over 80% report that their children currently live with the other parent or with a relative (U.S. DOJ, 2000).

Most of the women who become incarcerated suffer from a variety of physical and mental health problems as well as substance abuse issues and the great majority of the women have histories of trauma and abuse. Many whom are incarcerated lack the social and cognitive skills for successful reintegration into society. Successful reintegration can be measured by stable employment, housing, support of dependants, and volunteer service in the community (Lucenti & Gorczyk, 2005).

Parenting and Incarceration: Effects on Children

Children of parents who are sentenced to prison face a myriad of challenges, including potential future deviance, antisocial behavior and post traumatic stress. Incarceration can be generational in nature and 47% of female inmates reported to have had at least one member of their immediate family who had been incarcerated. About 35% of the women had a brother and 10% had a sister who had served a jail or prison sentence, 16% had a father who had served jail time (U. S. DOJ, 2000). Oklahoma has the largest female prison rate per capita in the Unites States and a recent study of incarcerated women in Oklahoma by Susan Sharp (2005) yielded that incarceration can be intergenerational. A total of 65 incarcerations of relatives were reported

by 54 female inmates in the study. 7.4% of prisoners had a mother who had been incarcerated, 20.4% had a father, 24% had an aunt or uncle and 25.9% had a brother who had been in prison. Indeed it is also this author's experience that incarceration of family members is a frequent occurrence.

Parental malfeasance is also a salient risk factor for child and adolescent antisocial behavior. An article by Mark Eddy and John Reid from the Oregon Social Learning Center (2001) examines the effect of parental incarceration and anti-social behavior on children and adolescents. They overview the relationship between parental criminality and incarceration and adolescent antisocial behavior and discuss how these factors might be linked through parenting. Eddy and Reid estimate that from "15 to 20% of the youth of the most antisocial parent(s) will become delinquent, and from 47 to 62% of all of those who will become delinquent will have at least one antisocial parent". Sharp (2005) reported that depression and decreased school performance were regular occurrences in children after their mothers went to prison.

Eddy and Reid (2001) also report that children of offenders face the risk of prenatal exposure to drugs and/or alcohol, which is related to a host of problems during childhood and adolescence (Olds, Henderson, & Kitzman, 1994). Capaldi, Pears, Patterson. & Owen, (2003) found that "longitudinal researchers show that parents who have antisocial characteristics are more likely to use harsh and ineffective parenting practices, which may verge on abuse".

Adolescent Pregnancy Rates, Live Births and Adoption

Each year more than 760,000 teenagers from age 15 to 19 become pregnant, and most adolescents who decide to have their babies, are choosing to raise them on their own. The trend

toward adoption has decreased sharply. Although data on adoption among teens is not available, among never-married women of all ages who have a birth, adoption is a relatively uncommon outcome. Among never married women who gave birth before 1973, 8.7% relinquished their babies for adoption and in 1999 .9% decided on adoption for their babies (Planned Parenthood, 2006). While the overall rate of pregnancies among teens has decreased since the 1970's the rate of pregnancy is still quite high. 2003 data shows that women from age 15 to 19 had 425,493 live births. There were also 7,315 lives births in adolescents under the age of 15 (Guttmacher Institute, 2006). Adolescents from economically disadvantaged communities with substance abuse or other behavior problems who are behind in school and have low aspirations for their own educational attainment are more likely to have a child (Planned Parenthood, 2006).

The young women and adolescents that come into the Lund Family Center programs are highly at risk for continued deviance and return to drug abuse, depression and poverty (Coe, 2007). Their histories are common to those in most literature on at risk youths: impoverished backgrounds, histories of sexual and physical abuse at the hands of loved ones, history of drug abuse and often unhealthy families of origin (Little & Rankin, 2001). These factors combined with the inclination of adolescents to keep their babies are detrimental to the wellbeing of all involved. Nair, Schuler, Black, Kettinger & Harrington (2003) assessed the relationship between cumulative environmental risks and early intervention, parenting attitudes, potential for child abuse and child development in substance abusing mothers. They studied 161 substance-abusing women, from a randomized longitudinal study of a home based early intervention, who had custody of their children through 18 months. "Ten maternal risk factors were assessed: maternal depression, domestic violence, non-domestic violence, family size, incarceration, no significant other in home, negative life events, psychiatric problems, homelessness, and severity of drug

use". Parental stress and child abuse potential were rated at 6 and 18 months post partum. They found that "compared to drug-abusing women with fewer than five risks, women with five or more risks found parenting more stressful and indicated greater inclination towards abusive and neglectful behavior, placing their infants at increased risk for poor parenting, abuse and neglect". The clients of the Lund Family Center usually face at least 6 of the risk factors noted in this study.

Traditional Treatment for Depression and Substance Abuse

Depression

Women experience depression twice as often as men (Bhatia & Bhatia, 1999) and addiction and depression as coinciding conditions are common. The National Institute of Health reported that almost one third of people with diagnoses of depression also suffered from some type of addiction (Daley, 2007). The National Cormorbidity Survey found that alcohol dependent women were four times as likely to be diagnosed with depression (Kessler, 2003). "The Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition (American Psychiatric Association, 1994) is the current reference used by mental health professionals and physicians to diagnose mental disorders. The current DSM-IV lists over 200 mental health conditions and the criteria required for each one in making an appropriate diagnosis.

Following are symptoms of depression; people should have 5 out of 9 of these symptoms and they should be present for at least a two week period of time: depressed mood, reduced interest or pleasure in activities, weight loss or gain, fatigue or decreased energy, feelings of

worthlessness or guilt, insomnia or hypersomnia, agitated or slow behavior, frequent thoughts of death or suicide (Bhatia & Bhatia, 1999).

Treatment for depression consists of a broad array of interventions and activities. For mild moderate to severe depression, initial treatments can include antidepressant medication and for major depression electro-shock therapy may be included in the treatment regimen. Regardless of the treatment modality, it is advised that after 4 to 8 weeks of treatment if moderate improvement is not seen then a thorough review of the diagnosis is advised (American Psychiatric Association, 2002). Following is a general overview of popular treatments used in the United States. It is intended to be informational and it is not in the purview of this paper to create an exhaustive review.

The major drug treatments used to treat depression) include antidepressants in the selective serotonin reuptake inhibitor (SSRI) family such as Prozac, Zoloft, Paxil and Celexa/Lexapro. Drugs in the neurepinephrine plus serotonin family such as Effexor and Cymbalta. Monoamine oxidize inhibitors, and those that affect the dopamine system such as Wellbutrin(Saltzberg, 2007).

According to the American Psychiatric Association (2002), cognitive behavioral therapy and psychotherapeutic approaches have the best documented effectiveness in the literature on treatment of depression disorders. Psychodynamic therapy has been less well studied however it is claimed that when used as a specific treatment in addition to symptom relief through pharmacology, then it is associated with broader long term goals.

Substance Abuse

Treatment modalities vary and are dependant upon the severity of the abused substance and level of addiction. For instance a person who is trying to quit a nicotine addiction and is not a danger to others will be treated much differently than one who has been convicted of drunk driving or is abusing drugs while pregnant. In general treatment for patients with substance abuse disorders include psychiatric management, which may include pharmacological treatments, such as methadone for heroin addicted persons; psychosocial treatments such as cognitive behavioral therapies; motivational enhancement therapies, behavioral therapies such as contingency management; 12 step facilitation; family therapies; and group therapies.

Because substance abuse is often chronic, patients may require long term treatment. The phases of treatment can include psychiatric management, strategy for maintaining abstinence, efforts to improve overall functioning and relapse and additional treatments for co-occurring psychiatric diagnoses such as cognitive therapy for depression (American Psychiatric Association, 2006).

Positive Psychology and Depression

As noted earlier in this treatise, the traditional approach to clinical therapy of depression and mental illness has been on repairing deficits. Positive Psychology looks to not only addresses reparation but also prevention. Prevention of mental illness comes from "recognizing and nurturing a set of strengths, competencies, and virtues in young people-such as future mindedness, hope, interpersonal skills, courage, the capacity for flow, faith and work ethic" (Seligman, 2002). Positive psychologists believe that the traditional approach of dwelling on the negative aspects of client's lives only serves to amplify the negative, not the positive (Saltzberg,

2007). Following are three programs that use Positive Psychology approaches in the treatment of depression. There are many programs that use Positive Psychology practices in the treatment of mental illness, indeed types of cognitive behavioral therapy can fall within this category; however it is not within the scope of this project to create an exhaustive search on the literature. The programs of Positive Psychotherapy (Parks, Seligman and Rashid, 2006), Penn Resiliency (Jaycox, Reivich, Gillham, & Seligman, 1994) and Quality of Life Therapy (Frisch, 2006) are illuminated based upon the appropriateness to the potential subject base and their ease of application in a non-clinical setting.

Seligman (1998) believes that evidence is weak that any known biochemical state can cause unipolar depression and moderately strong that at least one known cognitive state, pessimistic explanatory style, can cause unipolar depression. Furthermore, Seligman, Rashid and Parks postulate that depression symptoms and causes are interrelated (2006). "The symptoms of depression often involve lack of positive emotion, lack of engagement, and lack of felt meaning, but these are typically viewed as consequences or mere correlates of depression". They suggest in fact that building positive emotion, engagement and meaning will ease depression. They call this "Positive Psychotherapy" (PPT).

Expounding on Seligman's (2002) assertion that happiness could be decomposed into three scientifically manageable components, positive emotion (the pleasant life), engagement (the engaged life) and meaning, (the meaningful life), Seligman, Parks & Rashid (2006) created preliminary but hopeful research that applied exercises to increase positive emotion, engagement and meaning. They found that "PPT delivered to groups significantly decreased level of mild to moderate depression through a 1 year follow up" and that "PPT delivered to individuals

produced higher remission rates than did treatment as usual and treatment as usual plus medication among outpatients with major depressive disorder".

Participants in the group therapy treatment were mild to moderately depressed college students, treated over a 6 week period with a 2 hour per week intervention. The group treatment included six positive exercises with homework: Using Your Strengths, Three Good things/Blessings, Obituary/Biography, Gratitude Visit, Active-Constructive Responding, and Savoring.

The individual therapy treatment participants were clients who were engaged in seeking treatment from the Counseling and Psychological services at the University of Pennsylvania. Inclusion in the program required that they fulfilled diagnostic criteria for suffering from major depressive disorder. PPT took place over 14 sessions and was customized to meet the client's individual needs. The following general overview provides the positive exercises that were conducted with homework: The role of positive emotion in psychopathology (the empty life), taking the Values in Action Inventory of Strengths (VIA-IS), amplifying the 3 pathways through strengths, discussing the broaden and build model, creating a blessings journal, gratitude letter, forgiveness letter, ABCDE model (optimism and hope), Active-Constructive Responding, preparing family tree of strengths, mentoring and the gift of time, savoring, review (Rashid, In press.

Appreciating that pessimistic explanatory style can influence depression; the Penn Resiliency Program (Jaycox, Reivich, Gillham, & Seligman, 1994) is another powerful program that utilizes Positive Psychology. Also know as the Penn Optimism Program, or POP, and the Penn Depression Prevention Program, this program is used to increase optimism and resilience in participants. It has been successful used in populations as diverse as adolescents, college

students, organizations, people with disabilities and parents. The curriculum is delivered via a classroom based format and is comprised of twelve 90-minute group sessions. The curriculum teaches cognitive-behavioral and social problem solving skills and is based in part on the cognitive-behavioral theories of depression. Students are encouraged to identify and challenge negative beliefs, use evidence to make more accurate appraisals of situations and events, and to use effective coping mechanisms when faced with adversity. In addition to the cognitive-behavioral component, students learn techniques for assertiveness, negotiation, decision-making, and relaxation.

Using the format of group exercises and homework, the program is usually divided into 7 skill areas 1) The "ABC's" that cover the relationship between antecedents, beliefs and consequences (emotions and behaviors, 2) avoiding thinking traps, 3) detecting deep underlying beliefs or "icebergs", 4) challenging beliefs, 5) gaining perspective, and the fast skills of 6) calming and focusing and 7) real-time resilience (Reivich and Shatté, 2003).

In the original research study, 231 students were randomized into either an 8 week prevention workshop that met in groups of 10, once per week for 2 hour sessions, or into an assessment-only control group. 3 year follow-up studies showed that the treatment group had significantly fewer episodes of generalized anxiety disorder, showed a trend toward fewer major depressive episodes and had significantly fewer moderate depressive episodes than the non-treatment group. Second, the workshop group had significantly fewer depressive symptoms and anxiety symptoms than the control group and had significantly greater improvements in explanatory style, hopelessness, and dysfunctional attitudes than the control group and these were significant mediators of depressive symptom prevention in the workshop group (Seligman, Schulman, DeRubeis & Hollon, 1999).

As noted earlier in this paper, true wellbeing encompasses many areas of a person's life. It requires an appreciation of one's approaches to happiness, character strengths, strong social relationships and virtues (Peterson, Park & Seligman, 2005b), (Peterson & Seligman, 2004) to get them there. Quality of Life Therapy (Frisch, 2006) acknowledges that wellbeing is multifaceted and requires intentionality and engagement. In this cognitive behavioral program, participants are "given tools for boosting satisfaction and fulfillment in any one of 16 specific areas of life in order to enhance overall contentment or quality of life. These areas include life goals-and-values, spiritual life, self-esteem, health, relationships, work, play, helping, learning, creativity, money, surroundings--home, neighborhood, community—and relapse prevention". Quality of Life Therapy supports clinicians in the integration of Positive Psychology into their clinical practices. Dr. Frisch has also created Quality of Life Coaching aimed at the non-clinical population.

Quality of Life Therapy begins with an evaluation of a client's overall life goals and overall quality of life, often with the use of the "Quality of Life Inventory". The second step is an assessment of the overall goals of the client. Again an inventory such as the Quality of Life Inventory or "Happiness Pie" is used. The third step is an analysis of the areas of life that are contributing to dissatisfaction. These are the target areas for treatment (Saltzberg, 2007).

A relatively recent arrival on the scene of positive applications and interventions, clinical research on Quality of Life Therapy is not widespread, however it is in progress in a number of domain areas. One research study, pertinent to this project was carried out by Rodrigue, Baz, Widows, and Ehlers (2005). They used Quality of Life Therapy in attempting to improve the quality of life in mood disturbance and social intimacy in patients wait-listed for lung transplants. "Several primary findings emerged from this study. First, a brief, targeted

psychological intervention, that is, Quality of Life Therapy, with wait-listed lung transplant patients leads to significant improvement in quality of life, mood disturbance, and social intimacy. Second, improvements in quality of life and mood appear to be maintained for as long as 3 months after treatment. Third, while supportive therapy/treatment as usual appears to yield some short-term benefits in mood, Quality of Life Therapy is a more effective treatment overall." (Rodrigue, Baz, Widows, and Ehlers, 2005).

Application

The Lund Family Center

The Lund Family Center located in Burlington, Vermont is one agency that is trying to stem the tide of generational criminality and substance abuse. A multi-site, multi-program organization that serves more than 4,000 individuals annually with the assistance of 104 employees and a $4.9 million budget, the Lund Family Center focuses on 3 goals, "Strengthening families, reducing childhood abuse and neglect and helping create new families through adoption". Their mission is to "help children thrive by serving families with children, pregnant or parenting teens or young adults, and adoptive families". To be a client of the agency, a young woman must have a mental health and/or substance abuse diagnosis and be pregnant or parenting. The women served by the organization range from age 13 to 22, and according to their Executive Director, 90% of these women have been in prison or are under some type of penal supervision. The need for these services in Vermont is great; as the state has the highest rate of illegal drug use among 12 to 25 year olds in the U.S. (Lund Family Center, 2007).

The organization's strengths lie in its human capital, solid community relationships and renowned programs. To appreciate the scope of the work that the Lund Family Center does, their development collateral material states that their primary programs are inclusive of the following:

- *Residential and Community Treatment*

  This gender-specific program serves pregnant and parenting young women and their children under the same roof. Programs include a full range of medical and mental health and substance abuse services.

- *Family Support and Resource*

  Each year, the parent child center serves more than 1,000 individuals. Services include full day childcare for infants to three-year olds including developmental assessments, parenting assessments, countywide parent education workshops, home based family support, and Reach Up welfare to work services. Education Services include: high school classes, curriculum agreements with sending schools, GED preparation, parenting classes, life skill classes, health classes, and physical education. In fiscal year 2006, the Lund Family Center made over 500 home visits to over 100 at-risk parents and children.

- *Adoption*

  Lund Family Center is Vermont's largest private nonprofit adoption agency. Last year, in partnership with the State of Vermont, Lund Family Center made nearly 200 adoptions possible. Lund Family Center services also include home studies, post-placement services, and search and reunion services.

While the staff and leadership of the agency do observe individual client successes, they largely see women released from their programs return to the distressed lives that they led pre-intervention; re-offending or substance abusing and living in poverty. Staff appreciates that Positive Psychology can contribute to the success of their client base and they have requested support with their programs, particularly with their residential clients.

The 2007 strategic plan also supports a Positive Psychology intervention in terms of the longer term goals for the clients. While the outcome statements do mention directed self-awareness and intentionality in terms of "Increase likelihood of follow-through on counseling, medication, etc.", "Consciously and actively work in and out of counseling sessions on self-identified outcomes", "Implement skills and learning from counseling to effect behavior change in a positive way" and "Increase ability utilize personal and community resources", there is a lack of focus on outcomes that would add to their client's wellbeing through self directed character strength identification, flourishing and enjoyment of more positive emotion.

Staff and Leadership Application

Noting the aforementioned program scope and high stress environment, the staff and management of the residential program have requested that a Positive Psychology program be created to address their needs as practitioners and employees of the agency. This concept arose during a 2 hour focus group held in April of 2007 with team members that included social workers, program directors and an agency psychologist. When the overview of Positive Psychology and its implication for application to clients was presented; the staff said that they wanted the benefits of the program for themselves as well.

The ensuing discussion yielded that employees are extremely passionate about their work, however the emotional challenges that the day- to- day, highly charged environment

presents drains their ability to maintain positive focus and resiliency in the workplace. Additionally the agency has just completed a large capital campaign, and is undergoing tremendous transition with an upcoming move into a new building the resulting new programs. Seeking balance between managing the immediacy of daily client related activities with the larger and broader scope of organizational program change and change management has presented a conundrum for the staff.

Science strongly suggests that truly positive organizations are consciously aware of both present, internal developmental needs and future, external strategic goals. That is, the best organizations, not unlike the best team athletes or group visionaries, are best served by simultaneously focusing on what lies directly ahead of them and is within their control as an individual player while, at the same time, maintaining strong peripheral vision of all that exists around them and what is important from a team perspective as well. So, for organizations, then, there exists both a people value proposition (internal developmental needs) and a client value proposition (external strategic objectives) that are of importance. When an organization prioritizes one proposition to the detriment of the other, imbalance naturally results (Luthans, Youssef & Avolio, 2007). The application of Positive Psychology to staff and leadership should address the concept of the Lund Family Center becoming a more positive organization.

Focus Group Information

The application plan is informed by interviews with the Executive Director and senior professional staff members from the Lund Family Center, research conducted on similar programs, an in-depth literature review of the client issues, and comprehensive reviews of agency performance plans, strategic objectives, organizational charts and an outline of their strategic plan. The plan is crafted from a Positive Psychology perspective and is also informed

by the author's own personal experiences in corrections, business and human resources. As part of a cross-functional team with the staff, the author has partnered to achieve strong senior level buy-in and created a plan that has proven effective in real world settings and contains critical elements that are based in leading edge science. This author's next steps will entail a knowledge share with other leaders and stakeholders and an eventual rollout to the organization as a whole.

Program Considerations

Each offender is a unique individual; yet as a group, offenders face feelings of failure, hopelessness, learned helplessness, and pessimism (Seligman, 2002). They also feel alienated from mainstream institutions and learn to be cynical and to manipulate the system. It will be important to create a program with content that the clients see as relevant to their needs as individuals. Seligman also believes that progress in the prevention of mental illness comes from "recognizing and nurturing a set of strengths, competencies, and virtues in young people; such as future mindedness, hope, interpersonal skills, courage, the capacity for flow, faith and work ethic. The program should address the following: promoting self regulation (Brown & Ryan, 2004), self-efficacy (Bandura, 1977) and decreasing learned helplessness; moving participants toward optimistic approaches to life; supporting participants in creating more positive emotion in their lives to take a "broaden and build" posture (Frederickson, 1998) and increasing positive communication styles (Fredrickson & Losada, 2005); and supporting participants in an understanding of their character strengths (Seligman & Peterson, 2004).

The goals of the program are ambitious, and the challenges that the Lund Family Center faces with programming in general are that the length of stay for the clients varies greatly, and when clients are in residence, they often miss classes or group meetings for illness or appointments. Therefore the program must be able to have segments that are salient in isolation.

Additionally it is important to recognize that the clients in the Lund Family Center do not regularly engage in activities that increase their happiness, and do not often ponder whether their lives include meaning, engagement and pleasure. They are young women under a tremendous deal of pressure from numerous sources. Helping them to appreciate the value of the power of positive emotion and tools with which to achieve it are important. Additionally the program should be easy to use and appropriate to the population at hand. For these reasons the Positive Psychotherapy model created by Seligman, Parks & Rashid (2006) will be used as the chosen intervention. One alteration has been made substituting the "obituary" exercise with the "best-self" exercise. Given the level of depression in the subject group and their youth, the "best-self" or positive introduction exercise seemed more appropriate.

Program Outline

Each session would be designed to build upon the previous module but would be structured to stand alone. Sessions would be held once a week and it would be up to the staff member to determine a regular time of day. The agency has over 30 hours of programming time in addition to academics, so inclusion should not be difficult. It would be important to allow non-residents to attend as well. The center does have classes that would yield themselves to this structure and the clients are encouraged to do activities such as journaling; so the program should fit nicely into the curriculum. The program as a whole would run for 6 weeks with a 1.5 hour per week intervention. The group treatment will include six positive exercises with homework. (See Appendices A – G for full workshop curriculums).

- Using Your Strengths
- Three Good things/Blessings
- You at your Best

- Gratitude Visit
- Active-Constructive responding
- Savoring

To initiate the staff to the concepts of the program and to orient them to the training, the staff would be trained in a 6 week period before the program would be introduced to the clients. Because the exercises are all-embracing it would be intended that this portion of the program would address the staff's needs for wellbeing as well. Follow-up will have to be maintained however to assess whether more programs such as stress hardiness or employee engagement training should be implemented. Staff interviews yielded evidence suggesting that greater celebration of successes, and enhanced leadership and professional development programs may be of benefit to the organization; which is out of the scope of this project.

Outcomes and Measurements

The Lund Family Center has stressed the importance of measuring outcomes in this year's strategic plan. Because Internal Review Board approval from the University of Pennsylvania was not sought for this project, outcomes measurements will need to be provided by the Lund Family Center. Suggested assessments for consideration are shown below and many can be accessed either through paper or the internet.

- Approaches to the Happiness Questionnaire: To assess meaning making.
- The PANAS Questionnaire: Increased positive to negative affect ratios will be assessed. If found, increases in P-N ratios suggest greater team building and more harmonious working relationships (Watson, Clark & Tellegen, 1988)
- Attributional Style Questionnaire (ASQ): Several of the modules are aimed at teaching the difference between pessimistic and optimistic explanatory style. The ASQ, measures

explanatory style scores. (Peterson, Semmel, von Baeyer, Abramson, Metalsky & Seligman, 1982).

- Optimism Test: This test will act to support the ASQ. As noted previously, optimistic people tend to be more successful many life arenas, including work (Seligman, 2002).
- Authentic Happiness Inventory: This scale seeks to understand and provide an overall score to how happy one is with various aspects on life, and may be used as a good indicator of what is going well and where some changes may be made. (Peterson, 2005).

Table 1

Habits of Mind (Costa & Kallick, 2000)

Persisting	Thinking about thinking (metacognition)
Thinking and communicating with clarity and precision	Taking responsible risks
Managing impulsivity	Striving for accuracy
Gathering data through all senses	Finding humor
Listening with understanding and empathy	Questioning and posing problems
Creating, imagining, innovating	Thinking interdependently
Thinking flexibly	Applying past knowledge to new situations
Responding with wonderment and awe	Remaining open to continuous learning

Appendix A: Lund Family Center Workshops-Session 1: Signature Strengths
Adapted from (Garmen, 2007)

Objective/Topic	Content	Method/Activity	Time
Pre-Session Preparation	Overall objective of session to : o Engage participants in reflection of own strengths o Identify Signature Strengths o Show application o Engage in the understanding of the importance of their strengths to their work and life as a whole	<u>Supplies</u> Post its Handouts Flip chart & markers Snacks & beverages Abbreviated Strengths Test (Hefferman, 2007)	90 min
Welcome and Opening	Review agenda and objectives Read inspiration and discuss: "*My ethical principle in the first place was*: '*Where could I use my talents that God gave me to help the most people?*'" Sir John Templeton	Write agenda on flip chart Write objectives on Flipchart	10 min.
Underlying Principle	Our strengths are part of us in work and life. We want to highlight our strengths as individuals and apply them to our happiness and wellbeing We can change how we work together by appreciating our individual strengths and acknowledging them.		5 min
Reflect on existing strengths	This exercise will help us all reflect on our strengths. Looking for the signs of strengths helps to integrate the approach.	On a piece of paper, have clients write out the answers to the following questions: **S**uccess - What are you good at? Look back on the last week; identify any activities that you were good at. **I**nstincts - "I can't help but be good at…." Over the past week, what particular activities did you actually look forward to or volunteered for? **G**rowth - Naturally	15 min.

		inquisitive; focuses your energy. What do you do that makes time flies? You feel tired, but never drained. **N**eeds - When do you feel in control; authentic?	
VIA Assessment **Group Work**	This abridged test will help us further clarify our thoughts. Shared experience will help instill strengths application	Participants take the abridged Values in Action Survey In groups of 2 participants share how they can use their strengths more each day	25 min
Homework **Pre- discussion**	Take the VIA-IS online at http://www.authentichappiness.sas.upenn.edu/ or review the Abbreviated Strengths Test Finding ways in the next week to use your strengths in novel ways every day. Journal about the results		

Appendix B-Abbreviated Strengths Inventory (Hefferman, 2007)

	Description	Not Like Me	Somewhat Like Me	A Lot Like Me
Wisdom & Knowledge				
Curiosity and interest in the world	You are curious about everything. You are always asking questions, and you find all subjects and topics fascinating. You like exploration and discovery.			
Love of learning	You love learning new things, whether in a class or on your own. You have always loved school, reading, and museums-anywhere and everywhere there is an opportunity to learn.			
Judgment, critical thinking, and open-mindedness	Thinking things through and examining them from all sides are important aspects of who you are. You do not jump to conclusions, and you rely only on solid evidence to make your decisions. You are able to change your mind.			
Creativity, ingenuity, and originality	Thinking of new ways to do things is a crucial part of who you are. You are never content with doing something the conventional way if a better way is possible.			
Social intelligence	You are aware of the motives and feelings of other people. You know what to do to fit in to different social situations, and you know what to do to put others at ease.			
Perspective	Although you may not think of yourself as wise, your friends hold this view of you. They value your perspective on matters and turn to you for advice. You have a way of looking at the world that makes sense to others and to yourself.			
Courage				
Bravery and valor	You are a courageous person who does not shrink from threat, challenge, difficulty, or pain. You speak up for what is right even if there is opposition. You act on your convictions.			
Industry, diligence, and perseverance	You work hard to finish what you start. No matter the project, you "get it out the door" in timely fashion. You do not get distracted when you work, and you take satisfaction in completing tasks.			
Honesty, authenticity, and genuineness	You are an honest person, not only by speaking the truth but by living your life in a genuine and authentic way. You are down to earth and without pretense; you are a "real" person.			

Appendix B-Abbreviated Strengths Inventory (Hefferman, 2007)

Love		Not Like Me	Somewhat Like Me	A Lot Like Me
Kindness and generosity	You are kind and generous to others, and you are never too busy to do a favor. You enjoy doing good deeds for others, even if you do not know them well.			
Capacity to love and be loved	You value close relations with others, in particular those in which sharing and caring are reciprocated. The people to whom you feel most close are the same people who feel most close to you.			
Justice				
Citizenship, teamwork, and loyalty	You excel as a member of a group. You are a loyal and dedicated teammate, you always do your share, and you work hard for the success of your group.			
Fairness, equity, and justice	Treating all people fairly is one of your abiding principles. You do not let your personal feelings bias your decisions about other people. You give everyone a chance.			
Leadership	You excel at the tasks of leadership: encouraging a group to get things done and preserving harmony within the group by making everyone feel included. You do a good job organizing activities and seeing that they happen.			
Temperance				
Forgiveness and mercy	You forgive those who have done you wrong. You always give people a second chance. Your guiding principle is mercy and not revenge.			
Self-control and self-regulation	You self-consciously regulate what you feel and what you do. You are a disciplined person. You are in control of your appetites and your emotions, not vice versa.			
Caution, prudence, and discretion	You are a careful person, and your choices are consistently prudent ones. You do not say or do things that you might later regret.			
Modesty and humility	You do not seek the spotlight, preferring to let your accomplishments speak for themselves. You do not regard yourself as special, and others recognize and value your modesty.			

Appendix B Abbreviated Strengths Inventory (Hefferman, 2007)

Transcendence		**Not Like Me**	**Somewhat Like Me**	**A Lot Like Me**
Appreciation of beauty and excellence	You notice and appreciate beauty, excellence, and/or skilled performance in all domains of life, from nature to art to mathematics to science to everyday experience.			
Gratitude	You are aware of the good things that happen to you, and you never take them for granted. Your friends and family members know that you are a grateful person because you always take the time to express your thanks.			
Hope, optimism, and future-mindedness	You expect the best in the future, and you work to achieve it. You believe that the future is something that you can control.			
Spirituality, sense of purpose, and faith	You have strong and coherent beliefs about the higher purpose and meaning of the universe. You know where you fit in the larger scheme. Your beliefs shape your actions and are a source of comfort to you.			
Humor and playfulness	You like to laugh and tease. Bringing smiles to other people is important to you. You try to see the light side of all situations.			
Zest, enthusiasm, and energy	Regardless of what you do, you approach it with excitement and energy. You never do anything halfway or halfheartedly. For you, life is an adventure.			

Appendix C: Lund Family Center Workshops-Session 2: Three Good Things/Blessings

Objective/Topic	Content	Method/Activity	Time
Pre-Session Preparation	Overall objective of session to : o Appreciation of the focus on the positive o Beginning of gratitude for the small things o Support habit forming focus on what is good in life	<u>Supplies</u> Post its Handouts Flip chart & markers Snacks & beverages	90 min
Welcome and Opening	Review agenda and objectives Read inspiration and discuss: *Let us rise up and be thankful, for if we didn't learn a lot today, at least we learned a little, and if we didn't learn a little, at least we didn't get sick, and if we got sick, at least we didn't die; so, let us all be thankful.* Buddha	Write agenda on flip chart Write objectives on Flipchart	10 min.
Underlying Principle	Gratitude helps us feel better and appreciate what we have If we think about it, we can find something to be grateful for everyday Our lives are a series of moments and the more that we can notice what our blessings are as the day goes on, the happier we will be. We can change how we live by noticing this.		5 min
Reflect on Gratitude	This exercise will help us all reflect on our what we have to be grateful for right now	On a piece of paper, have clients write out the answers to the following questions: What do I have right now that I am grateful for? Why did this happen?	15 min.
Group Work	Have the group share their blessings list	In groups of 2 participants have them share their blessings	25 min
Homework	Reinforcing this will help you with your wellbeing and can help with depression	At night before bed write 3 things that happened and why you think they happened.	

Appendix D: Lund Family Center Workshops –Session 3: You at Your Best

Objective/Topic	Content	Method/Activity	Time
Pre-Session Preparation	Overall objective of session to : o Help participants appreciate their gifts o Help them appreciate how they are at their best and how they feel when they share it.	<u>Supplies</u> Post its Handouts Flip chart & markers Snacks & beverages	90 min
Welcome and Opening	Review agenda and objectives Read inspiration and discuss: *The more you praise and celebrate your life, the more there is in life to celebrate.* Oprah Winfrey	Write agenda on flip chart Write objectives on Flipchart	10 min.
Underlying Principle	We are at our best when we are acting in ways that bring out our strengths.		5 min
Reflect on self and others as positive influences	This exercise will help us all share who we are at our best and get to know each other better.	On a piece of paper, have clients write out the answers to the following questions: How do I feel when I am at my best? What things am I doing when I am at my best?	15 min.
Group Work	Have the group share their best selves	In groups of 2 participants have them share their results. One can share with the group	25 min
Homework		Participants can write their best self exercise in their journals.	

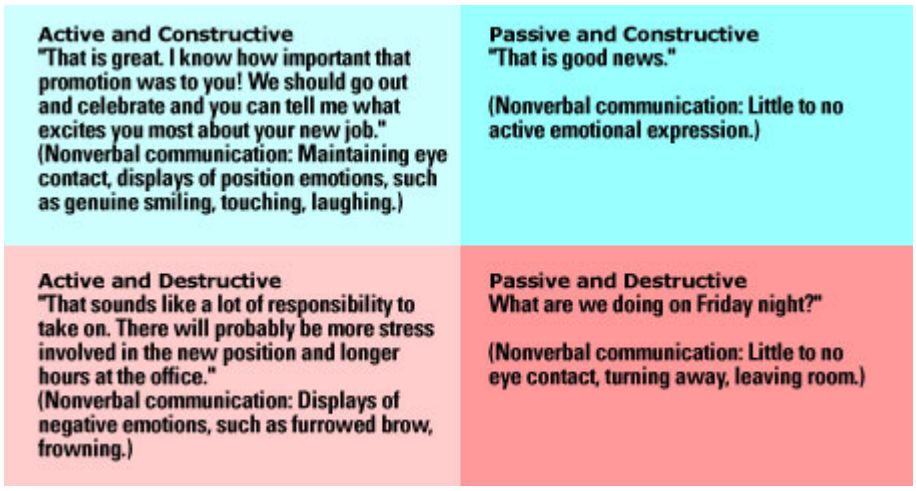
Appendix D: Lund Family Center Workshops –Session 4: Gratitude Visit

Objective/Topic	Content	Method/Activity	Time
Pre-Session Preparation	Overall objective of session to : o Help participants focus on others o Create feelings of gratitude for others o Initiate feelings of elevation o Support them in sense of community	<u>Supplies</u> Post its Handouts Flip chart & markers Snacks & beverages	90 min
Welcome and Opening	Review agenda and objectives Read inspiration and discuss: *Feeling gratitude and not expressing it is like wrapping a present and not giving it."* William Arthur Ward	Write agenda on flip chart Write objectives on Flipchart	10 min.
Underlying Principle	Gratitude: is a wonderful feeling of thanks that, when expressed, brings positive emotions to both initiator and recipient.		5 min
Reflect	This exercise will help us all reflect who we are grateful for in our lives	On a piece of paper, have clients write out the answer to the following: Is there anyone in my life that has helped me or made a difference in my life that I want to thank?	15 min.
Group Work	Shared experience will help instill application	In groups of 2 participants have them share their writing.	25 min
Homework	The act of writing the letter will bring some joy and the anticipation of knowing that the person will have joy at this letter will increase the positive impact.	Pick someone who has been kind and helpful to you, but has not heard your personal expression of thanks. Write a gratitude letter to the person you pick, expressing your gratitude and why you are grateful in specific and concrete terms. Mail it or hand deliver it	

Appendix E: Lund Family Center Workshops –Session 5: Active-Constructive Responding,

Objective/Topic	Content	Method/Activity	Time
Pre-Session Preparation	Overall objective of session to : o Appreciate the role that they have in other's happiness o Active listening and reacting improves understanding	<u>Supplies</u> Post its Handouts Flip chart & markers Snacks & beverages Model of Response Styles	90 min
Welcome and Opening	Review agenda and objectives Read inspiration and discuss: *Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around.* Leo Buscaglia	Write agenda on flip chart Write objectives on Flipchart Share the Model of Response Styles (Appendix F)	20 min.
Underlying Principle	The manner in which you respond when others share triumph with you directly builds or undermines your relationships.		5 min
Reflect	An active constructive response is one where you react in a visibly positive and enthusiastic way to good news from someone else.	On a piece of paper, have clients write out the answer to the following: Think about a time when you heard some good news from someone close. How did you respond? Could you have done it any differently?	15 min.
Group Work		In groups of 2 participants have them share their writing.	25 min
Homework	The act of writing the letter will bring some joy but the anticipation of knowing that the person will have joy at this letter will increase the positive impact.	At least once a day, respond actively and constructively to someone you know.	

Appendix F -Model of Response Styles (Gable, Reis, Impett & Asher, 2004)



Appendix G – Lund Family Center Workshops- Session 6: Savoring

Objective/Topic	Content	Method/Activity	Time
Pre-Session Preparation	Overall objective of session to : o Appreciate the role that savoring has in building positive emotion o Understand that this takes no money and can improve our moment to moment happiness	<u>Supplies</u> Post its Handouts Flip chart & markers Snacks & beverages Model of Response Styles	90 min
Welcome and Opening	Review agenda and objectives Read inspiration and discuss: *There are only two ways to live your life. One is as if nothing is a miracle, and the other is as if everything is a miracle.* Albert Einstein	Write agenda on flip chart Write objectives on Flipchart	10 min.
Underlying Principle	To savor is to be fully alive in the moment.		5 min
Reflect	Savoring is a type of meditation that you can enjoy at any time. It relaxes you and makes you smile.	On a piece of paper, have clients write out the answer to the following: Think of an experience you enjoy (eating chocolate, listening to music, holding your child, feeling your baby move inside of you. Now, consider ways in which you might intensify this experience. You can decrease distractions or use as many senses as possible.	15 min.
Group Work		In groups of 2 participants have them share their writing.	25 min
Homework	The act of savoring will help you appreciate and slow down to enjoy life more.	At least once a day, take the time to enjoy something you usually hurry through.	

References

Alan Guttmacher Institute (2006). U.S. Teenage Pregnancy Statistics: National and State Trends by Race and Ethnicity. Retrieved June 16, 2007 from http://www.guttmacher.org/pubs/2006/09/12/USTPstats.pdf.

Authentic Happiness. Retrieved May 8, 2007, from http://www.authentichappiness.sas.upenn.edu/testcenter.aspx.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*. 84. Retrieved June 10, 2007, from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=847061&dopt=Abstract.

Baumeister, R. F., Gailliot, M., DeWall, C. N., & Oaten, M. (In press). Self-regulation and personality: How interventions increase regulatory success, and how depletion moderates the effects of traits on behavior. *Journal of Personality*.

Bhatia, S.C. & Bhatia, S.K. (1999) Depression in Women: Diagnostic and Treatment Considerations. *American Family Physician, 60, 1*. Retrieved June 25, 2007, from http://www.aafp.org/afp/990700ap/225.html.

Boyatzis, R. & Van Oosten, E. (2002). Developing emotionally intelligent organizations. In Roderick Miller (ed.). *International Executive Development Program* . London : Kogan Page Publishers. Retrieved October 18, 2006, from http://www.eiconsortium.org/research/.

Brown, K.W., & Ryan, R.M. (2004) Fostering healthy self-regulation from within and without: A self-determination theory perspective. In Linley, P. A. & Joseph, S. (Eds.), *Positive psychology in practice* (pp. 105-124). Hoboken, NJ: Wiley.

Capaldi, D. M., Pears, K. C., Patterson, G. R. & Owen, L. D. (2003). Continuity of parenting practices across generations in an at-risk sample: A prospective comparison of direct and mediated associations. *Journal of Abnormal Child Psychology,* 31, 127-142. Retrieved June 24, 2007, from psycINFO database.

Coe, K. (2007) Interview regarding success and risk factors for client transition from the Lund Family Center. South Burlington, Vermont.

Compton, W. C. (2005). Positive psychology interventions. In *An Introduction to Positive Psychology* (pp. 182-195). Belmont, CA: Wadsworth.

References

Costa, A. L. & Kallick, B (2000). *Habits of Mind: A Developmental Series.* Association for Supervision and Curriculum Development in Alexandria, VA. Retrieved May 20. 2007, from http://www.habits-of-mind.net/.

Csikszentmihalyi, M. (1990). Flow: The psychology of optimal experience (pp. 23-42). New York: HarperPerennial.

Diener, E., Emmons, R., Larsen, R., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment,* 49, 1, 71-79.

Eddy, J. M. & Reid, J. B. (2001). The Antisocial Behavior of the Adolescent Children of Incarcerated Parents: A Developmental Perspective. Retrieved June 16, 2007, from http://aspe.hhs.gov/hsp/prison2home02/eddy.htm.

Fordyce, M. W. (1977). Development of a program to increase personal happiness. *Journal of Counseling Psychology 24(6), 511-521.*

Fordyce, M. W. (1997). Educating for happiness. Revue Quebecoise de psychologie, 18 (2),

Fredrickson, B.L. (1998). What good are positive emotions? *Review of General Psychology, 2(3),* 300-319.

Frederickson, B. L. (2002). Positive Emotion. In Snyder, C. R., & Lopez, S. J. (Eds.), *Handbook of positive psychology* (pp. 120-133). New York: Oxford.

Fredrickson, B.L. & Losada, M.F. (2005). Positive affect and the complex dynamics of human flourishing. *American Psychologist, 60(7),* 678-686.

Frederickson, B. L. (2006). Understanding Positive Emotions. Presentation for the University of Pennsylvania Master's of Applied Positive Psychology Class. Philadelphia.

Frisch, M. B. (2006). Quality of Life Therapy: Applying a life satisfaction approach to positive psychology and cognitive therapy. Hoboken: Wiley & Sons.

Gable, S. L., Reis, H. T., Impett, E. A., (2004). What do you do when things go right? The intrapersonal and interpersonal benefits of sharing positive events. *Journal of Personality and Social Psychology, 87, 2, 228-245.*

Garmen, K.A. ED.d. (2007). Personal e-mail communication, March 24, 2007.

Gorczyk, J. (2006). Personal communication November 15, 2006.

Gram, D. (2007). Psych meds use seen as high in Vermont. Prisons. The Bennington Banner.

References

Greene, J. & Pranis K. (2004) The Punitiveness Report: Hard Hit-The growth of imprisonment of women 1977-2004. Women's Prison Association. Retrieved June 15, 2007 from http://www.wpaonline.org.

Haidt, J. (2006). The Happiness Hypothesis: Finding modern wisdom in ancient truths. New York: Basic Books.

Hefferman, W. (2007). Abbreviated VIA-IS Strengths assessment. Retrieved from K. Reivich, E-mail on April 14, 2007.

James, W. (1892).Selections from Principles of Psychology: Briefer Course.

Jaycox, L.H., Reivich, K.J., Gillham, J.E., & Seligman, M.E.P. (1994). Prevention of depressive symptoms in school children. Behavior Research and Therapy, 32 (8), 801-816.

Karasu, T.B. et al (2000).Practice Guideline for treatment of patients with major depressive disorder, 2nd edition. American Psychiatric Association. Retrieved July 9, 2007, from http://www.psych.org/psych_pract/treatg/pg/Practice%20Guidelines8904/MajorDepressiveDisorder_2e.pdf.

Kessler, R. C. (2003). National Comorbidity Survey: Replication (NCS-R), 2001-2003. National Institute of Mental Health. Retrieved, July 9, 2007, from http://webapp.icpsr.umich.edu/cocoon/SAMHDA-STUDY/04438.xml.

Kleber, H.D. et al (2006).Practice Guideline for treatment of patients with substance abuse disorder, 2nd edition. American Psychiatric Association. Retrieved July 9, 2007 from http://www.psych.org/psych_pract/treatg/pg/SUD2ePG_04-28-06.pdf.

Little, C. B., & Rankin, A. (2001). Why do they start it? Explaining reported early-teen sexual activity. *Sociological Forum, 16, 4*, 703-729.

Lucenti, R. & Gorczyk, J. (2006). Workforce Development Program. Vermont Department of Corrections. Retrieved December 13, 2006, from http://wdp.doc.state.vt.us/index.html.

Lund Family Center (2007). Strategic planning material.

Luthans, F., Avolio, B.J., & Youseff, C. (2007). *Psychological capital: Developing the human competitive edge.(pp.11-143).* Oxford Press.

Maddux, J.E. (2002).Self-efficacy: *The power of believing you can*. In Snyder, C. R., & Lopez, S. J. (Eds.), *Handbook of positive psychology* (pp. 277-287). New York: Oxford University Press.

References

Maslow, A. (1982). *Toward a Psychology of Being*. (2nd ed.). New York: Van Nostrand Reinhold.

Melchert, N. (2002). Aristotle: The reality of the world. The good life. In The great conversation: A historical introduction to philosophy, 4th ed. (pp. 186-198). Boston: McGraw-Hill.

Mutrie, N. & Faulkner, G. (2004). Physical activity: Positive psychology in motion. In Linley, P. A. & Joseph, S. (Eds.), *Positive Psychology in Practice*. Hoboken, NJ: Wiley.

Nair, P., Schuler, M.I., Black, M.M., Kettinger, L., & Harrington, D. (2003). Cumulative environmental risk in substance abusing women: early intervention, parenting stress, child abuse potential and child development. *Child abuse and neglect, (9), 993-995. Retrieved June 24, 2007, from* http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=14550328&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVAbstractPlus.

O'Brien, P. & Addams, J. (2002). Reducing barriers to employment for women ex-offenders: mapping the road to reintegration. Safer Foundation. Retrieved December 13, 2006, from http://www.saferfoundation.org/docs/womenspolicypaper.pdf.

Olds, D. L., Henderson, C. R., & Kitzman, H. (1994). Does prenatal and infancy nurse home visitation have enduring effects on qualities of prenatal caregiving and child health at 25 to 50 months of life? *Pediatrics*, 93(1), 89-98.

Pawelski, J. O. (2003). William James, positive psychology, and healthy-mindedness. *The Journal of Speculative Philosophy (New Series) 17, 53-67.*

Pawelski, (2006). Positive Interventions. Presentation to the Master's of Applied Positive Psychology Class, October 29, 2006. Philadelphia.

Peterson, C. (2006). *A primer in Positive Psychology*. New York. Oxford University Press

Peterson, C., Park, N., & Seligman, M.E.P. (2005b). *Orientations to Happiness and Life Satisfaction: The Full Life Versus the Empty Life*. Journal of Happiness Studies, 6, 25-41.

Peterson, C., & Seligman, M.E.P. (2004). *Character strengths and virtues: A handbook and classification.* New York. Oxford University Press.

Peterson, C., Semmel, A., von Baeyer, C., Abramson, L.Y., Metalsky, G. I., Seligman, M.E.P. (1982) The Attributional Style Questionnaire. *Cognitive Therapy and Research, 6*, 287-299. Retrieved April 8, 2007 from http://www.authentichappiness.sas.upenn.edu/testcenter.aspx7

References

Planned Parenthood of Indiana: Adolescent fact sheet. Retrieved June 16, 2007 from https://www.ppin.org/documents/adolecent_preg_fact_sheet_06.pdf.

Rashid, T. (in press). Positive Psychotherapy- a twelve step model.

Regier D.A, Narrow, W.E., Rae, D.S., et al. (1993).The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50(2), 85-94.*

Reivich, K. & Shatté, A. (2003). The Resilience Factor: 7 keys to finding your inner strength and overcoming life's hurdles. New York. Broadway Books.

Rodrigue, J. R., Baz, M.A., Widows, M.R., & Ehlers, S.L. (2005). "A Randomized Evaluation of Quality of Life Therapy with Patients Awaiting Lung Transplantation". *American Journal of Transplantation, 5 (10), 2425-2432.*

Ryff, C. D., & Singer, B. (2002). From social structure to biology: Integrative science in pursuit of human health and well-being. In Snyder, C. R., & Lopez, S. J. (Eds.), *Handbook of Positive Psychology*. New York: Oxford University Press.

Salovey, P., Caruso, D., & Mayer, J. D. (2004). Emotional intelligence in practice. In Linley, P. A. & Joseph, S. (Eds.), *Positive psychology in practice*, 447-463). Hoboken, NJ: Wiley.

Saltzberg, J. (2007). Special Topics in Positive Psychology and Clinical Work. Presentation to the Master's of Applied Positive Psychology Class, March 31, 2007. Philadelphia

Seligman, M.E.P., Rashid, T. & Parks, A. C. (2006). *Positive Psychotherapy*. American Psychologist, 774-787.

Seligman, M.E.P (1998). Is depression biochemical? *The APA Monitor, 29, 9*. Retrieved July 5, 2007 from http://www.apa.org/monitor/sep98/pc.html.

Seligman, M.E.P. (2002). *Authentic Happiness*. New York. Free Press.

Seligman, M. E. P.; Schulman, P., DeRubeis, R. J., Hollon, S. D. (1999) The prevention of depression and anxiety. *Prevention & Treatment. 2, 1*.Retrieved July 1, 2007, from http://content.apa.org/journals/pre/2/1/8.

Self Determination Theory: An approach to human motivation and personality. Retrieved October 21, 2006, from http://psych.rochester.edu/SDT/measures/mindfulness.html

References

Shapiro, S.L. & Schwartz, G.E. (2000).Intentional systemic mindfulness: an integrative model for self-regulation and health. Advances in mind-body medicine, 16(2), 128-34. Retrieved October 19, 2006, from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=Display&DB=pubmed.

Shapiro, S.L., Schwartz, G. E., & Santerre, C. (2002). Meditation and positive psychology. In Snyder, C. R., & Lopez, S. J. (Eds.), *Handbook of Positive Psychology*. New York: Oxford University Press.

Sharp, S. (2005). Oklahoma study of incarcerated mothers and their children-part 2. Presented to the Oklahoma commission on children and youth. Retrieved June 24, 2007 from http://www.wfok.org/downloads/OKIncarcMothersChildren2.pdf.

Tedeschi, R. & Calhoun, L. (1995). *Trauma & Transformation*. CA: Sage Publications.

U.S. Department of Justice (2005) The Nation's prison population continues its slow growth-up 1.9 percent last year. Office of Justice Programs release. Retrieved June 17, 2007 from http://www.ojp.gov/newsroom/2005/BJS06002.htm.

U.S. Department of Justice Bureau of Justice Statistics (2000). Incarcerated Parents and Their Children. Retrieved June 17, 2007 from http://www.ojp.usdoj.gov/bjs/abstract/iptc.htm.

U.S. Department of Justice, Office of Justice Programs, Bureau of Justice (1994). Statistics Women in Prison Bureau of Justice Statistics Bulletin. Retrieved June 17, 2007 from http://www.ojp.usdoj.gov/bjs/pub/ascii/wopris.txt.

Walmsley, R. (2006) World Population Prison list. *International Centre for Prison Studies*. Retrieved June 17, 2007 from http://www.kcl.ac.uk/depsta/rel/icps/women-prison-list-2006.pdf.

Watson, D., Clark, L.A. & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: *The PANAS scales. Journal of Personality and Social Psychology, 54,* 1063-1070.

Wong, P. T. P. (2003) Pathways to posttraumatic growth: Presidents message to International Network on Personal Meaning, Coquitlam, B.C., Canada. Retrieved July 11, 2007, from http://www.meaning.ca/archives/presidents_columns/pres_col_may_2003_post-traumatic-growth.htm.